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IN THE

Supreme Court of the United States

JOHN SELIG, IN HIS OFFICIAL CAPACITY AS DIRECTOR OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Petitioners,

v.

PEDIATRIC SPECIALTY CARE, INC., ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF STATES AND STATE AGENCIES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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The States and state Medicaid agencies listed below respectfully submit this brief of *amici curiae* in support of petitioners in this case.[1] Letters indicating the consent of parties to the filing of this brief have been filed with the Clerk.

INTEREST OF *AMICI CURIAE*

Amici curiae administer the joint federal-state program known as Medicaid, subject to oversight by the federal government. State Medicaid officials are regularly called on to interpret the federal Medicaid statute and regulations and to make policy decisions about how the program should be implemented.

Amici have a strong interest in this case. The court of appeals affirmed denial of summary judgment to Arkansas Medicaid officials who sought qualified immunity in connection with their implementation of a prior authorization program designed to control the use of certain medical services. As described below, if allowed to stand, the decision below will materially impede States' efforts to deal with the growing cost of the Medicaid program, threatening state officials with personal liability for implementing policies designed to control costs.

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than *amici*, their members, or their counsel, made a monetary contribution to the preparation or submission of this brief.

STATEMENT

Medicaid — the primary source of health care for the needy in the United States — is one of the largest and fastest growing programs of the federal government and of each of the States and territories. Managing that growth, and controlling its cost, is perhaps the most important–and difficult issue of public administration confronting state governments today. The decision below, if allowed to stand, will materially impede States' efforts to deal with this issue, threatening state officials with personal liability for implementing policies to control cost.

1. Medicaid is a joint federal-state program established in 1965 by Title XIX of the Social Security Act ("Act"), Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396 *et seq.* (2000 & Supp. III)). A State participates in Medicaid pursuant to a State Plan, approved by the Secretary of Health and Human Services, who has delegated this function to the Administrator of the Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS). The State Plan establishes eligibility groups, the various services to be provided, and the reimbursement rates to be paid to the entities that provide those services. *See* 42 U.S.C. § 1396a (2000 & Supp. III); 42 C.F.R. § 430.10 (2005). States receive partial federal reimbursement for payments made for approved "medical assistance" under the State Plan. 42 U.S.C. § 1396b (2000 & Supp. III).

While each State is responsible for designing and administering its own Medicaid program, States must operate their programs in compliance with a multitude of federal statutory and regulatory guidelines. Among other things, a State Plan must "include reasonable standards . . . for determining . . . the extent of medical assistance;" it must provide safeguards to ensure that care and services are provided "in a manner consistent with simplicity of

administration and the best interests of the recipients;" and it must provide such methods and procedures "as may be necessary to safeguard against unnecessary utilization of such care and services" and to ensure that "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(17), (19), (30)(A) (2000 & Supp. III).

Most of the services that may be provided as medical assistance are expressly enumerated in the statute. *See* 42 U.S.C. § 1396d(a)(1)-(3) (2000 & Supp. III) (listing inpatient hospital services, outpatient hospital services, laboratory, and x-ray services). However, some categories of medical assistance are more nebulous in their scope. For example, Section 1905(a)(13) of the Act permits States to cover, at their option,

> other diagnostic, screening, preventive, and rehabilitative services . . . recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level.

42 U.S.C. § 1396d(a)(13). Similarly broad language can be found in the requirement that individuals under the age of 21 receive "early and periodic screening, diagnostic and treatment services" — the so-called "EPSDT" benefit — including any service listed in the statute that is necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered . . . whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(a)(4)(B), (r)(5). The broad wording of these two

provisions has been at issue in a number of recent decisions requiring States to provide children with services that are not expressly required or defined in the statute, the implementing regulations, or any other federal guidance to the States.[2]

2. The States' obligation to cover certain care and services under the Medicaid program is balanced by their authority and obligation to ensure that the scope of Medicaid expenditures is necessary and appropriate. States are authorized to conduct a "utilization review" to "safeguard against unnecessary utilization of such care and services." 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III). For each service provided, federal regulations give States flexibility to establish reasonable parameters, so long as each service is "sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b) (2005). State Medicaid agencies are encouraged to "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." *Id.* § 440.230(d).

This authority extends to EPSDT services as well. In its State Medicaid Manual (SMM), CMS gives States the "flexibility within the Federal Statutes and regulations to design an EPSDT program that meets the health needs of recipients." SMM ¶ 5010(C) (1990). CMS permits and also encourages the use of utilization control procedures for EPSDT services. *See* SMM ¶ 5122(F) (1994) ("[42 C.F.R. § 440.230] allows you to establish the amount, duration and scope of services provided under the EPSDT benefit.");

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[2] *See, e.g., S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 596 (5th Cir. 2004) (incontinence underwear); *Katie A. v. Bontá*, 433 F. Supp. 2d 1065, 1075 (C.D. Cal. 2006) ("therapeutic foster care"); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 32 (D. Mass. 2006) (home-based supports for seriously emotionally disturbed children); *Collins v. Hamilton*, 231 F. Supp. 2d 840 849 (S.D. Ind. 2002) (residential psychiatric treatment); *Emily Q. v. Bontá*, 208 F. Supp. 2d 1078, 1090 (C.D. Cal. 2001) (therapeutic behavioral services).

SMM ¶ 5230.1(A) (1990) (States may cooperate with Maternal and Child Health programs to develop health services policies and standards for EPSDT, including assessments "with a view toward eliminating unnecessary services; duplication; providing acceptable quality of care, and integrating and providing all necessary services").

States may institute utilization controls by contracting with federally-certified peer review organizations, known as Quality Improvement Organizations (QIOs). 42 U.S.C. § 1396a(d) (2000 & Supp. III); 42 C.F.R. §§ 431.630, 456.2 (2005). QIOs review and approve requests for Medicaid services, before such services are provided, to determine whether they are medically necessary and "sufficient in amount, duration, and scope." 42 C.F.R. § 440.230(b) (2005). If a QIO physician denies the requested service, the recipient or provider can request reconsideration. 42 U.S.C. § 1320c-3(a)(3)(A)-(D) (2000 & Supp. III).

3. This case involves claims under 42 U.S.C. § 1983 brought against the Arkansas Department of Human Services (ADHS),[3] an ADHS contractor, and several ADHS officials who were sued in their individual, as well as official, capacities. The Fifth Amended Complaint, brought by providers of Child Health Management Services (CHMS) and several beneficiaries, alleged that changes made to the State's CHMS program violated the Medicaid statute.[4]

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[3] ADHS (now the Arkansas Department of Health and Human Services) administers the Medicaid program in Arkansas.

[4] CHMS is a multi-disciplinary program created by Arkansas that combines various therapies and early intervention day treatment for pre-school children who "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions." *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472, 475 (8th Cir. 2002) (internal quotation mark omitted) (quoting Arkansas Medicaid Manual at II-19). The suit was in response to the State's attempt to eliminate the early intervention day treatment component from the state Medicaid Plan. Early intervention day treatment "is a type of day care (continued...)

Plaintiffs sought declaratory and injunctive relief and damages, including punitive damages.

In 2002, the Eighth Circuit affirmed a decision of the district court that "early intervention day treatment" was an EPSDT service that Arkansas was obligated to pay for under its Medicaid program. *Pediatric Specialty Care, Inc v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002). Thereafter, the plaintiffs challenged the "prior authorization" program ADHS had put in place to control utilization of the service.

In the decision below, the court of appeals considered the argument of two of the state officials — Ray Hanley and Roy Jeffus — that the district court erred in denying them qualified immunity from claims that they had violated rights under the Medicaid statute by implementation of the prior authorization process, which allegedly resulted in a reduction in the level of day treatment provided to children through CHMS. The court of appeals discussed at length the conduct of employees of Arkansas Foundation for Medical Care (AFMC), a QIO the State had engaged to administer the prior authorization process. *See* page 5, *supra*. Among other things, AFMC employees were alleged to have altered physician treatment recommendations and denied claims in order to reduce costs in an effort to obtain renewal of the contract.

The court of appeals concluded that under the Medicaid statute children had a clearly established right to receive the maximum level of treatment recommended by a provider physician and that reductions in day treatment resulting from use of the prior authorization process violated

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program run by early childhood specialists and overseen by medical staff. The curriculum is structured to ameliorate conditions discovered by the EPSDT evaluations and to strengthen the skills children learn in therapy." *Id.* at 476 n.2.

that right. *See* Pet. App. 13-19. While terming it a "difficult question," the court concluded that Hanley and Jeffus could be tied to the alleged wrongdoing of the AFMC employees. It stated that the officials "'implemented a policy [of prior authorization] that reduced the scope and duration of day treatment for beneficiaries of the Medicaid Act.'" Pet. App. 20 (alteration in original) (quoting Dist. Ct. Order of Feb. 7, 2005, at 38). According to the court, "Taking the evidence in the plaintiffs' favor, one could infer that [Hanley's and Jeffus'] primary motivation was to save money, although the statutes require them to act in the best interest of the needy children." Pet. App. 20. The court termed this "a violation of the rights clearly established under the §§ 1396d(a)(13) and 396a(a)(30)(A) [sic] and our prior case law" and affirmed the denial of the officials' summary judgment motions. Pet. App. 20.

SUMMARY OF ARGUMENT

The court of appeals' decision affirming denial of qualified immunity for two state Medicaid officials cannot be reconciled with this Court's decisions. The conclusion that use of a prior authorization program designed to control costs violated a clearly established right to Medicaid services is inconsistent with the statutory scheme and the legal standards articulated in this Court's qualified immunity decisions. The court of appeals adopted an unjustifiably expansive view of what constitutes a "clearly established right" under the Medicaid statute, embracing an interpretation that fails to give any weight either to the State's authority to establish the amount, duration, and scope of services that it will reimburse or to the federal policies favoring utilization controls. At a minimum, the alleged rights were not clearly established. Particularly when a plaintiff seeks to impose personal liability on a state official based on policy decisions implementing a complex federal-state program like

Medicaid, the "clearly established" test must be applied with care.

If the decision below is allowed to stand, it will cause serious practical problems for all States. State officials responsible for administering federal-state programs will face the threat of devastating personal financial liability when they implement policies designed to prevent misuse of state and federal funds. Even a remote prospect of such crippling liability will make it difficult for States to recruit qualified candidates for these positions. At a minimum, the decision will impede the efficient administration of the Medicaid program because state officials will be reluctant to institute utilization controls. In view of these serious practical consequences, the petition should be granted.

ARGUMENT

The undersigned States and state Medicaid agencies urge the Court to grant review to address a question of great significance to the States, concerning the availability of qualified immunity for state officials who administer federal-state programs. The court of appeals ventured into uncharted territory when it concluded that the alleged efforts of two Arkansas officials to control the cost of a service covered by the state Medicaid program may have violated a "clearly established right" to that service, depriving them of the protection of qualified immunity from suit. So far as *amici* are aware, the conclusion that a state policymaker may be personally liable under Section 1983 for implementing cost-control strategies is unprecedented.

If the decision below is allowed to stand, there will be serious practical consequences for States and for their ability to administer federal-state programs efficiently. This Court

should grant *certiorari* to correct the court of appeals' error and to prevent the significant harm that will follow if the decision is permitted to stand.[5]

I. The Court of Appeals Decided an Important Question Involving Qualified Immunity for State Officials in a Way That Cannot Be Reconciled with Decisions of This Court.

The court of appeals' conclusion that Arkansas Medicaid officials are not entitled to immunity from personal liability in connection with introduction of a prior authorization process departs from this Court's precedents. Because use of prior authorization review for Medicaid services did not violate any clearly established federal right, and in fact promotes the federal policy encouraging utilization controls for Medicaid, the state officials were entitled to qualified immunity.

A. To Ensure the Smooth Functioning of Government, Courts Must Grant Immunity to State Officials Whose Conduct Does Not Violate a Clearly Established Right.

Public officials who perform discretionary acts in good faith are entitled to qualified immunity from claims against them in their personal capacities under Section 1983. Such protection is needed "to shield [public officials] from

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[5] In addition to challenging the rejection of qualified immunity, the petition argues that the two provisions of the Medicaid statute on which the court of appeals relied — 42 U.S.C. § 1396a(a)(30)(A) (providing for utilization review and payment rates that permit access to services) and 42 U.S.C. § 1396d(a)(13) (defining "medical assistance" to include certain rehabilitative services) — do not create private rights enforceable under 42 U.S.C. § 1983. In concluding that these provisions create enforceable rights, the court failed to engage in the rigorous analysis of whether a statute includes "rights-creating" language required by this Court's recent precedents. *See Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002); *Blessing v. Freestone*, 520 U.S. 329 (1997).

undue interference with their duties and from potentially disabling threats of liability." *Harlow v. Fitzgerald*, 457 U.S. 800, 806 (1982).[6] As this Court has recently recognized, "The nub of qualified immunity is the need to induce officials to show reasonable initiative when the relevant law is not 'clearly established.'" *Will v. Hallock*, __ U.S. __, 126 S. Ct. 952, 960 (2006) (quoting *Harlow*, 457 U.S. at 818). Respect for state officials' initiative is particularly appropriate in the context of Medicaid, a federal-state partnership in which state officials must act as the responsible stewards of both federal and state funds in administering a program tasked with addressing the needs of many different groups with sometimes competing demands.

When ruling on a public official's summary judgment motion seeking qualified immunity, a court must determine first whether, taken in the light most favorable to the plaintiff, the facts alleged show that the official's discretionary conduct violated a federal constitutional or statutory right, taking into account the backdrop of law at the time of the conduct. *See Brosseau v. Haugen*, 543 U.S. 194, 197-98 (2004) (*per curiam*); *Saucier v. Katz*, 533 U.S. 194, 201 (2001). If the answer is affirmative, then "the next, sequential step is to ask whether the right was clearly established." *Saucier*, 533 U.S. at 201.

This Court has required lower courts to assess whether a right is clearly established "'in light of the specific context of the case, not as a broad general proposition.'" *Brosseau*, 543 U.S. at 198 (quoting *Saucier*, 533 U.S. at 201). An officer is entitled to qualified immunity even where

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[6] Qualified immunity is an immunity from suit, not merely a defense to liability. *See Mitchell v. Forsyth*, 472 U.S. 511, 526 (1985). This Court has held that "a district court's denial of a claim of qualified immunity, to the extent it turns on an issue of law, is an appealable 'final decision' within the meaning of 28 U.S.C. § 1291 notwithstanding the absence of a final judgment." *Id.* at 530.

she "reasonably misapprehends the law governing the circumstances she confronted." *Id.* Thus, qualified immunity protects public officials from the need to litigate claims against them in their personal capacity, except where federal law provided them with fair notice that their conduct was improper. *See id.* at 198-99.

B. The Conclusion That a Policy to Control Costs in the Medicaid Program Violated a Clearly Established Right to Medicaid Services Is at Odds With This Court's Guidance on Qualified Immunity.

The court below held that petitioners Hanley and Jeffus, who were responsible for administration of the Medicaid program in Arkansas, did not enjoy immunity from claims that they had violated the Medicaid statute. According to the court, the prior authorization program petitioners implemented resulted in a reduction in the amount of treatment provided to children, and, "[t]aking the evidence in the plaintiffs' favor, one could infer that [petitioners'] primary motivation was to save money, although the statutes require them to act in the best interest of the needy children." Pet. App. 20.[7] The court held that such conduct violated rights clearly established under §§ 1396d(a)(13) and 1396a(a)(30)(A).

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[7] The court cited ADHS "directives to AFMC about the extent of services that AFMC could approve." Pet. App. 20. However, it stopped short of suggesting that either Hanley or Jeffus was personally involved in issuing any such directives. It appears that there was only one "directive" issued by Hanley, and none by Jeffus. *See* Pet. App. 41. This "directive," an estimate of expected savings included in the initial notice of the prior authorization program, was simply the financial impact statement required for all rules promulgated under Ark. Code Ann. § 15-204(d)(1) and (d)(4) — hardly evidence that Hanley and Jeffus had a purpose of reducing payments to a pre-determined level, much less evidence of an intent to violate any federal right.

This conclusion is wrong in every respect. It is plainly inconsistent with this Court's decisions because institution of utilization controls — an act expressly permitted by statute — with the motivation to save money cannot possibly be a violation of a clearly established right. Moreover, the court of appeals' holding disregards the reality that state officials have an obligation to be responsible guardians of the state and federal funds that support Medicaid services. Implementation of utilization controls to achieve cost savings is not only lawful, it is key to efficient use of public funds.

1. There Is No Federal Right, Much Less a Clearly Established One, to Medicaid Services Free of Prior Authorization.

There is no right under the Medicaid statute to receive Medicaid services free from a prior authorization process. In fact, the sentence containing one of the provisions cited by the court of appeals — the so-called equal access provision[8] — also requires State Plans to include "such methods and procedures relating to the utilization of . . . care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services. . . ." 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III); *see also* 42 C.F.R. §§ 440.230(d), 456.3(a) (2005).

Federal law permits prior authorization as a form of utilization control. Indeed, federal regulations specifically provide for prior authorization in connection with services provided in hospitals, mental hospitals, and intermediate care

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[8] This provision requires that payments to providers be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III).

facilities. *See* 42 C.F.R. §§ 456.60(a), 456.160(a), 456.360(a) (200 The Act rewards peer-review arrangements, inc ng those involving prior authorization, by providing enhanced federal matching to States that contract with private QIOs for this purpose. 42 U.S.C. § 1320c-7(b) (2000). CMS has encouraged prior authorization procedures for EPSDT services. *See* SMM ¶ 5230.1(A) (1990) (States may develop EPSDT assessments "with a view toward . . . eliminating unnecessary services").[9]

Far from being unlawful, the motivation of containing costs is an entirely appropriate (indeed, laudable) reason for a State to implement a prior authorization process. Prior authorization has the potential to achieve cost savings by screening out medically unnecessary services. There is no tension between a cost-saving motive and ensuring that medically necessary services are available to Medicaid-eligible children to the same extent they are available to the general population. *See* 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III).[10] A plurality of this Court has noted, in the context of a prescription drug prior authorization

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[9] Indeed, federal agencies have counseled States against provision of overly expansive Medicaid rehabilitative services for children. In 2000, an HHS publication advised that rehabilitative services, in general, are not available for the long term treatment of people with only developmental delays. *See* U.S. Dep't of Health & Human Services, *Understanding Medicaid Home and Community Services: A Primer* 11 (2000). More recently, the Government Accountability Office expressed concern that States may be classifying as "rehabilitative," and claiming under Medicaid, services for children that are actually the responsibility of other state agencies. U.S. Government Accountability Office, *Medicaid: States' Efforts To Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight* 18-19 (June 28, 2005).

[10] While the EPSDT benefit at issue in this case is expansive, it is limited to medically necessary services. *See* 42 U.S.C. § 1396d(r)(5) (2000 & Supp. III) (defining EPSDT benefit as encompassing "*necessary* health care, diagnostic services, treatment, and other measures") (emphasis added). The goal of prior authorization is to achieve accuracy in determining medical necessity.

requirement, that "[a]voiding unnecessary costs in the administration of a State's Medicaid program" is a valid "Medicaid purpose" for the policy, and that a State's decision to implement prior authorization (even when motivated by a state policy unrelated to the Medicaid statute) should be viewed in light of the "'considerable latitude' that characterizes optional participation in a jointly financed benefit program." *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 663-64, 666 (2003) (quoting *King v. Smith*, 392 U.S. 309, 318 (1968)); *see also id.* at 676 (Thomas, J., concurring in the judgment) (concluding that the Act gives States "broad discretion to impose prior authorization"); *cf. id.* at 685 (O'Connor, J., concurring in part and dissenting in part) (a State "may impose prior authorization to reduce Medicaid costs"). Lower courts have reached similar conclusions. *See Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 825-26 (D.C. Cir. 2004); *Grier v. Goetz*, 402 F. Supp. 2d 876, 905-06 (M.D. Tenn. 2005).

The court of appeals found it significant that the prior authorization process had resulted in a reduction in the amount of day treatment authorized for children, noting that the process "essentially led to a wholesale reduction in CHMS services from six hours per day, per child to no more than three and one-half to four hours per day, per child." Pet. App. 6. However, the statute does not entitle Medicaid recipients to any particular quantity of services. Services such as CHMS are intended for "the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13) (2000 & Supp. III). But this does not mean that the level of services a provider recommends cannot be reduced if an independent reviewer concludes that a portion of those services is not medically necessary.

The court of appeals asserted that its earlier decisions in this litigation clearly established the alleged rights. *See*

Pet. App. 15. But these decisions focused on different aspects of Arkansas' administration of Medicaid rehabilitative services for children; neither decision even discussed the prior authorization process. *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993), also cited by the court of appeals (Pet. App. 15), likewise did not involve a prior authorization process or appropriate means for evaluating medical necessity. The court there held only that, before implementing a rate reduction for services, a State must consider the factors listed in 42 U.S.C. § 1396a(a)(30)(A).[11] In any event, the authority cited earlier in this section makes clear that the rights alleged by plaintiffs were not clearly established.[12]

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[11] 6 F.3d at 529-30. The court of appeals also cited the deposition testimony of a psychologist for the proposition that children do better with more hours of treatment. *See* Pet. App. 6. This is not evidence that the alleged right to six hours of day treatment is clearly established.

[12] The court of appeals may have concluded that it could impute to petitioners the conduct of employees of AFMC, the contractor charged with administering the prior authorization process. Such imputation would be improper. The court did not suggest that Hanley and Jeffus personally participated in any of the alleged AFMC wrongdoing (*e.g.*, unauthorized revision of physician recommendations). Nor did the court cite anything in the AFMC contract that conflicted with the statute.

This Court has made clear that vicarious liability may not be imposed under Section 1983. *See Monell v. Dep't of Soc. Servs.*, 436 U.S. 658, 694 (1978); *see also id.* ("[A] local government may not be sued under § 1983 for an injury inflicted solely by its employees or agents"). This Court has not considered vicarious liability in connection with a claim against an individual public official. However, courts of appeals have rejected vicarious liability for officials sued in their individual capacity. *See, e.g., McQueen v. Beecher Cmty. Schs.*, 433 F.3d 460, 470 (6th Cir. 2006); *Evett v. DETNFF*, 330 F.3d 681, 689 (5th Cir. 2003).

2. The "Clearly Established" Test Must Be Applied With Care When Reviewing the Actions of State Officials Who Must Implement the Broad Mandates of the Medicaid Statute.

Even if there were a statutory right to receive particular Medicaid services free from a prior authorization process motivated by cost containment concerns, or a right to receive six (rather than four) hours of treatment per day, such a right certainly was not obvious. The court below departed from this Court's precedents when it held that such a right was clearly established.

In *Brosseau*, this Court instructed that broadly-worded precedents do not ordinarily provide public officials with fair notice that particular conduct is unlawful, warranting a denial of qualified immunity. 543 U.S. at 199. A prior decision holding that a police officer's use of excessive force violates the Fourth Amendment, for example, does not "clearly establish" that an officer is unjustified in shooting a disturbed suspect fleeing in a vehicle. *Id.* Instead, this Court in *Brosseau* reviewed other authority and determined that there was no consensus that that particular conduct constituted excessive force. *Id.* at 200-01. While there is no bright-line rule that the exact conduct at issue must have been held unlawful in a previous decision, the Court has explained that the unlawfulness of an action must be "'apparent'" in order to warrant denial of qualified immunity. *Hope v. Pelzer*, 536 U.S. 730, 739 (2002) (quoting *Anderson v. Creighton*, 483 U.S. 635, 640 (1987)).

The court of appeals disregarded these holdings, announcing in a conclusory manner that a prior authorization policy motivated by cost-saving concerns violates rights clearly established by the Medicaid statute. Pet. App. 20. The court defined the statutory obligation at issue as

"act[ing] in the best interest of the needy children." *Id.* Such an abstractly defined obligation cannot reasonably alert State Medicaid Directors that a specific policy is unlawful.

A careful analysis of whether an alleged right is "clearly established" is particularly important in a case involving state policymakers. This Court has rarely addressed qualified immunity for a state or local policymaker, and has never addressed the qualified immunity of a state policymaker responsible for implementing a federal-state program that confers significant autonomy on the State.[13] In this setting, the chief concern behind qualified immunity — encouraging state officials to tackle difficult problems — operates with particular force.

In fact, the decision below might be best described as an end-run around the constitutional limitations on suits against States. Unlike a case involving shooting of a suspect, this suit is essentially an attack on a state policy, rather than the individual action of a particular state official. As the court of appeals recognized, the Eleventh Amendment limits any action against Arkansas or its agencies to a suit against state officials in their official capacities for prospective injunctive relief, to force a change in the state policy. *See* Pet. App. 21. Retrospective relief, such as damages, against the State (or its officials when sued in their official capacity) is prohibited.[14] Plaintiffs' effort to recover damages from the

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[13] Only one recorded federal court decision has examined a state policymaker's qualified immunity for Medicaid decisions. In *Bethany Medical Center v. Harder*, 693 F. Supp. 968 (D. Kan. 1988), a district court granted qualified immunity to a state official who had allegedly failed to implement certain supplemental Medicaid payments for hospitals, despite a statutory command to do so. Emphasizing the flexibility accorded to state Medicaid programs in interpreting and implementing the governing federal statutes, the court held that there was no violation of clearly established federal law. *Id.* at 979-81.

[14] *See, e.g., Frew v. Hawkins*, 540 U.S. 431, 437 (2004); *Edelman v. Jordan*, 415 U.S. 651, 668 (1974).

individual state policymakers, in amounts that would clearly be beyond the capacity of public officials to bear, should be seen as an effort to obtain through the back door a form of relief against the State that the Constitution prohibits.

II. If Not Reversed, the Decision Below Will Cause Severe Practical Problems for the States.

Unless this Court grants *certiorari* and reverses, the decision below will cause severe problems for States and for state officials charged with administering federal-state grant programs. As a result of the denial of qualified immunity, state officials responsible for administering the Medicaid program will be subject to a trial and will face potential personal liability for millions of dollars in damages based on their effort to control costs for one narrow category of services. Other state officials within the Eighth Circuit will be aware that they, too, may face a similar threat of personal liability if they institute utilization controls in an effort to control the inexorable increases in Medicaid spending. (Nothing in the decision suggests that its reasoning is limited to day treatment services.) State officials everywhere will be aware that other circuits may follow this precedent.

Even a remote threat of such massive personal liability may well dissuade qualified professionals from public service. States need expert administrators to handle the many large and complex federal-state programs that provide services to millions of residents. Medicaid, one of the largest of these programs, "gives each state flexibility in designing and administering its own Medicaid program." *La. Dep't of Health & Hosps. v. Ctr. for Medicare & Medicaid Servs.*, 346 F.3d 571, 572 (5th Cir. 2003). Each policy decision requires state officials to interpret complex federal laws and regulations, and reasonable minds can differ regarding what is required. It will be difficult for States to recruit candidates to administer such programs with the threat

of massive damages looming in connection with efforts to demonstrate fiscal responsibility.

In addition to making it difficult for States to recruit for policymaking positions, this precedent is almost certain to discourage state officials from introducing utilization controls or other cost-control measures. For years, Congress and federal officials have expressed concern about waste in federal programs, including spiraling costs in the Medicaid program, and have encouraged state officials to take steps to assure that expenditures of federal funds are prudent. The decision below creates just the opposite incentive.

CONCLUSION

The petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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